

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02422

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02422

1. DECEASED NAME (Type or Print) Earl Cearsa Ashby			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 4 Year 1969			2b. HOUR 4:50			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11/7/1880	6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED OEO Month 2 Day 4 Year 1969			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH GARRETT			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Oakland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 4	
14. FATHER'S NAME First Middle Last Marshall M. Ashby				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Beachy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 214-46-3689		17. INFORMANT ADDRESS Mrs. Dorothea Ashby (Wife) Rt. 4 Oak-land, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 441.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) RETROPERITONEAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED ABDOMINAL AORTIC SCLEROTIC ANEURYSM								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 1-2 HOURS "	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.O. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type) James H. Feaster, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> FEBRUARY 4, 1969			
ADDRESS (Street, city, town, or county) OAKLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/7/69		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland Maryland			
24. FUNERAL DIRECTOR Gerald N. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR FEB 11 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03132

03132

George A. Anderson

1913-1914

1914-1915

1915-1916

1916-1917

1917-1918

1918-1919

1919-1920

1920-1921

1921-1922

1922-1923

1923-1924

1924-1925

1925-1926

1926-1927

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1928-1929

1929-1930

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1931-1932

1932-1933

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1934-1935

1935-1936

1936-1937

1937-1938

1938-1939

1939-1940

1940-1941

1941-1942

1942-1943

1943-1944

1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>02428</div> <div> <div>1</div> <div>02423</div> </div>										
<div>1. DECEASED-NAME</div> <div>(Type or print) EDNA BLANCHE COSNER</div>					<div>2a. DATE OF DEATH</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>FEBRUARY 1 1969</div>		<div>2b. HOUR</div> <div>3:45PM</div>			
<div>3. SEX</div> <div>FEMALE</div>		<div>4. RACE</div> <div>WHITE</div>		<div>5. DATE OF BIRTH</div> <div>DECEMBER 26, 1886</div>		<div>6. AGE (In years last birthday)</div> <div>82 YRS.</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS DAYS HOURS MIN.</div>		
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>W.Va.</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>Garrett Md.</div>				
<div>10. CITY OR TOWN OF DEATH</div> <div>Oakland</div>			<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Garrett Co. Memorial Hosp.</div>			<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Housework</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Own Home</div>		
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>W.Va.</div>			<div>13b. COUNTY</div> <div>Grant</div>		<div>13c. CITY OR TOWN</div> <div>Mt. Storm</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>Rt. 42</div>	
<div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>Joseph Ellsworth Idleman</div>				<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Rosa Belle Cosner</div>						
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</div> <div>Yes, no, or unknown (If yes give war or dates of service)</div> <div>No</div>			<div>16b. SOCIAL SECURITY NO.</div> <div>234-62-4439</div>		<div>17. INFORMANT</div> <div>Mrs. Mae Cosner,</div>				<div>Address</div> <div>Mt. Storm, W.Va.</div>	
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) 4409 breemia</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Failure</div> <div>DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days - 10 days</div>										
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div>										
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>			<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>			
<div>21a. ACCIDENT WAS UNDERLYING</div> <div><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</div> <div>(If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M. Month Day Year</div> <div>19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>						
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Nat while <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>		<div>21f. LOCATION</div> <div>Street or R.F.D. No. City or Town County State</div>						
<div>22a. I certify that (I) (this hospital) attended the deceased from 1966, to 1969, that (I) (we) last saw the deceased alive on 1 Feb 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>										
<div>22b. SIGNATURE</div> <div>A.E. Mance</div> <div>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div>								<div>22c. DATE SIGNED</div> <div>2 Feb 69</div>		
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>A.E. Mance, M.D.</div>				<div>22e. ADDRESS</div> <div>Oakland, Md. 21550</div>						
<div>23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)</div> <div>Burial</div>		<div>23b. DATE</div> <div>Feb. 4/69</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Idleman Cemetery</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Mt. Storm, Grant Co, W.Va.</div>				
<div>24. FUNERAL DIRECTOR</div> <div>Wm. Mildred Shaughnessy</div>				<div>25a. REC'D BY REGISTRAR</div> <div>O. Kitzmiller, Md.</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>				

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02429

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02424

1. DECEASED-NAME (Type or Print) First Middle Last Waitman Bernard Dean			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month Day Year 2-28-69 19			2b. HOUR 6:50 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-7-86	6. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 28 Year 1969	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH GARRETT Md.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Farmer		12b. KIND OF BUSINESS OR INDUSTRY Gen. Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.			13b. COUNTY Upshur	13c. CITY OR TOWN Buchannon	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route #4,	
14. FATHER'S NAME First Middle Last George Dean			15. MOTHER'S MAIDEN NAME First Middle Last Lucinda Hinkle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 285-60-5398A		17. INFORMANT ADDRESS B. Dean, Accident, Maryland (Son)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			M.D. James H. Feaster, Jr., M. D.			22b. DATE SIGNED 2-28-69	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			ADDRESS (Street, city, town, or county) Oakland, Garr., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/3/69		23c. NAME OF CEMETERY OR CREMATORY Buchannon Memorial Park Buchannon, Upshur, W. Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR John O. Durst, Oakland, Maryland				25a. REC'D BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05430

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05430



FOR STATE HEALTH DEPT.

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02430 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02425									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF ESTI-DEATH MATED			2b. HOUR
Martha			Tilda			Fike			2-16 1969 449 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	1/28/1882	87 YRS.			Month 2 Day 16 Year 19 69			510 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA		GARRETT				Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Oakland			Cuppitt-Weeks Nursing Home			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland			Garrett		Vindex	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frank			McRobie			Hulda Harvey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			216-01-4821		Virgil Fike Baltimore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									Sudden
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									Years
(b) <u>Arteriosclerosis, generalized</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
<i>James H. Feaster, Jr.</i>			M.D.			2-16-69			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
James H. Feaster, Jr., M. D.						Oakland, Garr., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/19/69		Deer Park Cemetery		Deer Park, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Gerald N. Minnich</i>				Oakland, Md.		FEB 19 1969		<i>Charles Judge</i>	

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02431		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02426	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year
Charlotte Jean Gonder					February 13, 1969
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Female	White	Jan. 30, 1889		80 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	USA		GARRETT Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett Co. Mem. Hosp.		Homemaker		Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Garrett	Oakland		305 S. 3rd St.	
14. FATHER'S NAME First Middle Lost		15. MOTHER'S MAIDEN NAME First Middle Lost			
Andrew B. Gonder		Mary M. Casteel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
no		212-54-7865		B. I. Gonder, Sr. Oakland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>69</u> , <u>2-12-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-12-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>James H. Feaster, Jr.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-13-69</u>	
22d. PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr.		22e. ADDRESS Oakland, Maryland 21550			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	2/15/69	Oakland Cemetery		Oakland, Maryland 21550	
24. FUNERAL DIRECTOR <u>Gerald N. Minnich</u>		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE <u>FEB 19 1969</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

02420

02420

RECEIVED

DATE: 10/10/1960

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 11
30M REV. 1-69

02432				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02427			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Middle Last		Price		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR P	
Isabel		XXXXXX		Graser				February 3 1969		11:10	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Dec. 7, 1903		65					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Penna.		USA				Garrett					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Oakland		Gar. Mem. Hosp.		Housewife		Own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Garrett		Oakland				109 N. Second			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last									
William A. Underwood		Jesse Price									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
None		None		O.T. Graser, Oakland, Md. (Husband)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrum affected</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cereculocytes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>174X</u> <u>3 1/2 yrs</u> <u>ago</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>167</u> to <u>3 Feb 1969</u> , that (I) (we) last saw the deceased alive on <u>3 Feb 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A E Mance M.D.</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>5 Feb 69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Mance</u>		22e. ADDRESS <u>Oakland, Maryland 21550</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb. 7 1969		Oakland Cem.		Oakland, Garr., Md.					
24. FUNERAL DIRECTOR <u>John O. Dorst</u>		ADDRESS <u>Oakland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>					

73100

STATE OF OHIO

98380

Handwritten:
May 1900

Handwritten:
Bureau of
Geology

Vertical text on the right margin:
This is a copy of the original document and is not to be used for any other purpose.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

2

1

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR								
Annie Bell			Harden			February 5, 1969			M								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Female		White		Oct. 3, 1882			86 YRS.		MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.					
Md.			USA						GARRETT								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Oakland				Oak Rest Nursing Home				Housewife				Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Maryland				Allegheny				Frostburg				238 W. Mechanic St.					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
First Middle Last				First Middle Last													
Vandeneer Thorpe				Emma Koontz													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address					
Yes, no, or unknown				213-10-9697A				Mrs. Helen Nolan, Frostburg, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>												days					
4339 DUE TO, OR AS A CONSEQUENCE OF												yr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>Systemic sclerosis</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
<u>Gastritis</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				19													
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr</u> , 1966, to <u>Feb</u> , 1969, that (I) (we) last saw the deceased alive on <u>Feb 69</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE												DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>B. L. Grant, M. D.</u>																2-6-69	
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS					
B. L. Grant, M. D.												Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				Feb. 8 '69				Fbg. Memorial Park				Frostburg, Md.					
24. FUNERAL DIRECTOR ADDRESS												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph R. Durst, Frostburg, Md. 21532												DATE FEB 11 1969		<u>Charles Judge</u>			

1942

STATE OF TEXAS

1942

IN SENATE, FEBRUARY 11, 1942.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

ENDING DECEMBER

31, 1941.

BY

JOHN W. ...

COMMISSIONER

LAND OFFICE

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02429

02434

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Floyd Wellington Hill			2a. DATE OF DEATH Month Day Year February 25 1969		2b. AMR 10:10M
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH November 06, 1900		6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH GARRETT Md.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Radio
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 137 N. 3rd St.	
14. FATHER'S NAME First Middle Last Ray Hill		15. MOTHER'S MAIDEN NAME First Middle Last Beulah Fraley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) yes WW I		16b. SOCIAL SECURITY NO. 217-05-5781		17. INFORMANT Address Mrs. Wm. Evans Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinosis of liver</u> 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>68</u> , to <u>26 Feb</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>26 Feb</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. E. Mance</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>26 Feb 69</u>	
22d. PHYSICIAN'S NAME (Type) A. E. Mance		22e. ADDRESS Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/28/69	23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery	23d. LOCATION (City or Town) (County) (State) Terra Alta W. Va.		
24. FUNERAL DIRECTOR <u>Gerald N. Minnich</u>		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE <u>MAP</u> <u>5 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>

1942

RECEIVED

1942

TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

FROM THE CHIEF, BUREAU OF REVENUE, WASHINGTON, D. C.

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Vernie Grace Lantz						February 29, 1969		12:10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		Dec. 6, 1889		79 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
W.Va.		USA				Garrett		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Oakland			Garrett County Memorial Hospital			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
W.Va.			Preston		Aurora					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Lewis Hardesty			Laura Lantz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
None			None		Arlene Stemple, Aurora, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>									2 days	
4122 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u>Myocardial Infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1965, to Feb. 1969, that (I) (we) last saw the deceased alive on Feb. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. L. Grant</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 2-2-69		
22d. PHYSICIAN'S NAME (Type) Dr. B. L. Grant								22e. ADDRESS Oakland, Md. 21550		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		Feb. 5, 1969		Stemple Ridge		Aurora, Preston W.Va.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Lester R. Hinkle Davis, W.Va.				DATE FEB 10 1969		<u>[Signature]</u>				

00000

MINISTRY OF DEFENSE

SECRET

1. NAME OF THE PERSON: [illegible]
2. DATE OF BIRTH: [illegible]
3. PLACE OF BIRTH: [illegible]
4. OCCUPATION: [illegible]
5. EDUCATION: [illegible]
6. MILITARY SERVICE: [illegible]
7. CURRENT STATUS: [illegible]
8. COMMENTS: [illegible]

9. SIGNATURE: [illegible]
10. DATE: [illegible]

11. APPROVAL: [illegible]
12. REASON: [illegible]

13. COMMENTS: [illegible]
14. DATE: [illegible]

15. SIGNATURE: [illegible]
16. DATE: [illegible]

17. APPROVAL: [illegible]
18. REASON: [illegible]

19. COMMENTS: [illegible]
20. DATE: [illegible]

21. SIGNATURE: [illegible]
22. DATE: [illegible]

23. APPROVAL: [illegible]
24. REASON: [illegible]

25. COMMENTS: [illegible]
26. DATE: [illegible]

27. SIGNATURE: [illegible]
28. DATE: [illegible]

29. APPROVAL: [illegible]
30. REASON: [illegible]

31. COMMENTS: [illegible]
32. DATE: [illegible]

33. SIGNATURE: [illegible]
34. DATE: [illegible]

35. APPROVAL: [illegible]
36. REASON: [illegible]

37. COMMENTS: [illegible]
38. DATE: [illegible]

39. SIGNATURE: [illegible]
40. DATE: [illegible]

41. APPROVAL: [illegible]
42. REASON: [illegible]

43. COMMENTS: [illegible]
44. DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

02436										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02431																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										Hour																																							
JOSEPH (NONE) PERRY										FEBRUARY 9, 1969										3:35 M																																							
3. SEX Male										4. RACE White										5. DATE OF BIRTH Nov. 15, 1890										6. AGE (In years last birthday) 78 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) Penna.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH GARRETT Md.																													
10. CITY OR TOWN OF DEATH Oakland										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Miner										12b. KIND OF BUSINESS OR INDUSTRY Coal																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Garrett										13c. CITY OR TOWN Deer Park										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER Church St.																			
14. FATHER'S NAME First Middle Last unknown										15. MOTHER'S MAIDEN NAME First Middle Last unknown										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no										16b. SOCIAL SECURITY NO. 215-05-2095										17. INFORMANT Frank Perry										Address Deer Park, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Cerebral vascular accident, left										10 days																																																	
4124										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Arteriosclerotic cardiovascular disease										Years																																							
										DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1948, 19, to 2-9-69, 19, that (I) (we) lost saw the deceased alive on 2-9-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.																																																											
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 2-10-69																																							
22d. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.										22e. ADDRESS 104 S. 2nd. St., Oakland, Md. 21550																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2/12/69										23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery										23d. LOCATION (City or Town) (County) (State) Deer Park Maryland																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Gerald N. Minnich										Oakland, Maryland										DATE FEB 13 1969										Charles Young																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02437		02432						CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
ISABELLE V. RICKENBERG						2 Month Day Year 2 26 1969			1P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Aug. 16, 1875			93 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md.		USA					Garrett, Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Oakland			Cuppett-Weeks Nursing Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Allegheny		Oldtown				None		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
John H. Rickenberg			Elizabeth Barth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			None			Mrs. Hazel Haugh			Oldtown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>										day	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										yr -	
(b) <u>Arteriosclerosis of Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1967, to <u>Feb</u> , 1969, that (I) (we) lost the deceased on <u>2-25-69</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>B. L. Grant</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>2-27-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>B. L. Grant, M.D.</u>						22e. ADDRESS <u>Oakland, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			3/1/1969		Oldtown Cemetery			Oldtown, Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Byron Knight Cumberland, Md.						DATE <u>MAR 6 1969</u>			<u>Charles Judge</u>		

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Figure 5.20

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Mr. Robert E. Hendon, Jr., Chairman, Board of Directors, American Telephone and Telegraph Company, New York, New York

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Elbtown Cemetery

DOCLINE 101200

Chamberland, Md.

Figure 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 02438 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02433 </div>												
1. DECEASED-NAME (Type or print) HERMAN OTTO SCHMIDT						2a. DATE OF DEATH Feb. Month 7, Day 1969			2b. HOUR 10 P.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 13, 1900			6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett Md.						
10. CITY OR TOWN OF DEATH Rural - Swanton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Station			12b. KIND OF BUSINESS OR INDUSTRY Gasoline			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Henry August Schmidt				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Elizabeth Upole								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. H. O. Schmidt, Swanton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Casualty during Airplane 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months years years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 7 Feb 1969 , 19 69 , to 7 Feb 1969 , that (I) (we) last saw the deceased alive on 7 Feb 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE A. E. Mance						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 8 Feb 69			
22d. PHYSICIAN'S NAME (Type) A. E. Mance, M.D.						22e. ADDRESS Oakland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/10/69		23c. NAME OF CEMETERY OR CREMATORY Garr. Co. Mem. Garden			23d. LOCATION (City or Town) (County) (State) Oakland, Garrett, Md.					
24. FUNERAL DIRECTOR John O. Durst						ADDRESS Oakland, Md.			25a. REC'D BY REGISTRAR DATE FEB 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Lisa Carr Stephens						February 3, 1969			1:25 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		Sept. 4, 1968			YRS. 4		26
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				GARRETT Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland			Garrett Co. Mem. Hosp.			none		none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Oakland		YES		820 E. Green St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
McKinley Reed Stephens, Jr.			Betty Yvonne Carr						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			none		McKinley R. Stephens, Jr. Oakland, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration, severe, acute</u>									48 hours
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diarrhea, severe, and high fever</u>									48 hours
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastro - Enteritis, Acute</u>									72 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>February 2, 1969</u> , to <u>February 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Herbert H. Leighton</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 4 Feb 69	
22d. PHYSICIAN'S NAME (Type) Dr. H. H. Leighton					22e. ADDRESS Oakland, Md. 21550				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/4/69		Oakland Cemetery		Oakland Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gerald D. Munnich			Oakland, Maryland			FEB 11 1969		<u>[Signature]</u>	

STATEMENT OF DEATH

Line Carr Stephen February 3, 1952 1:12



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02440		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02435	
Item 23 Film 409 2/17/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Cora Lucetta Winters		2a. DATE OF DEATH Month Day Year February 5 1969		2b. HOUR A.M. P.M. 5:00 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 17, 1884	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years lost birthday) 84 YRS.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett County Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.		13b. COUNTY Preston		13c. CITY OR TOWN Egton	
14. FATHER'S NAME First Middle Last Charles Christman		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		16. SOCIAL SECURITY NO. [blank]	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No		17b. SOCIAL SECURITY NO. [blank]		17. INFORMANT Address Herbert Winters	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years years			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) [blank]		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. [blank]		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) [blank]	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) [blank]		21f. LOCATION Street or R.F.D. No. City or Town County State [blank]	
22a. I certify that (I) (this hospital) attended the deceased from 1950, to 2 Feb 1969, that (I) (we) last saw the deceased alive on 2 Feb 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. E. Mance		22c. DATE SIGNED 5 Feb 69		22d. PHYSICIAN'S NAME (Type) Dr. A. E. Mance	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Red House cemetery	
24. FUNERAL DIRECTOR Lester R. Hinkle		24b. ADDRESS Davis, W. Va.		25a. REGISTRY REGISTRAR FEB 10 1969	
23d. LOCATION (City or Town) (County) (State) Red House, Garrett Md.		23e. REGISTRAR'S SIGNATURE [blank]		23f. REGISTRAR'S SIGNATURE [blank]	

